Nashville – Davidson County
Tennessee
Child Fatalities
1997

Fourth Annual Report

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Executive Summary and Recommenda -tions

The Nashville Child Death Review Team was established by Executive Order in January 1994 with the goal of reducing child fatalities. The Team includes doctors, police officers, paramedics, nurses, behavioral health professionals, medical examiner, district attorneys, and child protective service workers.

During the 1997 calendar year, 110 Davidson County children died. After review the Team determined that thirty-two deaths could have been prevented. This report provides information about the deaths of these children. Much has been learned about the circumstances surrounding child deaths in Nashville and Davidson County. Hopefully this information will be used to guide both policy and action at State and local levels.

There is no one agency or organization in Nashville that has a complete picture of the circumstances surrounding the death of a child. The Team fills this gap by conducting confidential case reviews of deaths of children from birth through age seventeen. Through their collaborative work, they seek to understand why and how children are dying in Nashville and further, how the death may have been prevented.

This 1997 report is the fourth annual report compiled and includes a Four Year Data Summary. Data were entered into the Child Fatality Database and the findings are reported in this report.

Of the total 110 children who died, 79 died of natural causes. Nine of the natural deaths were attributed to SIDS (Sudden Infant Death Syndrome). The remaining deaths included thirty who died as a result of injury related deaths and one case where the manner of death could not be determined. Injury related deaths included 10 deaths from traffic accidents, 10 non-traffic accidental deaths, nine homicides, and one suicide. Of the non-traffic related deaths, seven died as result of firearms, six suffocated, three children drowned, two died in a fire, and one died as a result of inflicted injury.

Sixty nine infants died (from birth to 12 months). Eight children died between the ages of one and four, and eight children died between the ages of five and eleven. Twenty-five children between the age of 12 and 17 died. Of the 110 deaths during 1997, 76 were male, 34 were female. Table II on page 19 shows the leading causes of death ranked by age group over

the four-year period. Illness is the number one cause of death for children between birth and age 11. In adolescents, however, firearm related deaths was the leading cause over a four year period. Illness was the second leading cause and vehicular accidents claimed the third largest number of adolescents. Data over the four-year period strongly suggest that availability of guns is a factor in both suicides and homicides.

Additionally, data suggests that more effort should be placed on educating adolescents about the deadly combination of drugs, alcohol and operating a motor vehicle.

Team recommenda - tions

Team recommendations are listed below:

1. Team members agreed to convene a meeting, including but not limited to the OB/GYN Society, Tennessee Perinatal Association, March of Dimes, Metro Police Department, and the District Attorney's office to discuss the topic of prenatal child abuse. The goal of the meeting is to determine possible interventions (and/or solutions) for dealing with substance abuse during pregnancy.

2. The wording regarding risk factors on birth certificates should be clearer.

3. Nashville's Child Death Review Team would like to see a meeting between the Medical Examiner's office and the Nashville Fire Department Medical Director's office, to discuss whether paramedics may not begin or discontinue resuscitation on children who are obviously dead. Dr. Levy's office would like to have an investigator at the scene before a deceased child is removed.

4. The State Child Death Review Team should recommend a change in the way infant child death statistics are counted. Non-viable infant deaths should be captured in another category or excluded from infant deaths in order to demonstrate a clearer picture of infant mortality. To date the Team has reviewed several deaths that fall into the non-viable category.

5. The Metro Health Department should do a pool safety campaign annually. Channel 8 has a commercial showing a child drowning that should be aired on other channels.

6. The quality assurance process at the Department of Children's Services (DCS) should include a documented review of all DCS child death cases.

Introduction and Background Information

The Davidson County Child Death Review Team was established by Mayor Philip Bredesen through Executive Order No. 94-01 on January 5, 1994. The order required the Team of 10 to "review the death of any child below 18 years of age legally residing in Davidson County at the time of death." Additionally, the team explores the manner of death and recommends preventive strategies. The Mayor's Executive Order is found in Appendix I. The Team is mandated to prepare an annual report on child fatalities in Davidson County and to submit the report to the Mayor. In April 1995, the first annual report was published.

On June 12, 1995, Governor Don Sundquist signed the Child Fatality Review and Prevention Act of 1995. The Bill, which was sponsored by Representative Westmoreland and Senator Holcomb, created the Tennessee Child Fatality Prevention Team within the State Department of Health. Further, the legislation established local teams in each judicial district to review cases of child deaths before submission to the state team. The Bill is found in Appendix 2. Nashville's Team operated for eighteen months prior to the State legislation.

Team Objectives

The Nashville Child Death Review Team seeks to "identify: 1) causes of death for children under 18; 2) circumstances surrounding, and contributing to, preventable deaths; and 3) needed changes in legislation, policy and practice; with the goal of establishing preventative and interventive mechanisms that will reduce child fatalities".

Since its inception in January 1994, the Team has gathered data for four consecutive calendar years. The Chair of the Nashville Team serves on the Statewide Child Fatality Review Team. The Statewide Team addresses policy issues impacting children throughout the State.

Lisa A. Granik and others, Child Death Review Teams: A manual for Design and Implementation (Chicago, Illinois: American Bar Association,1991) p 1.

Findings

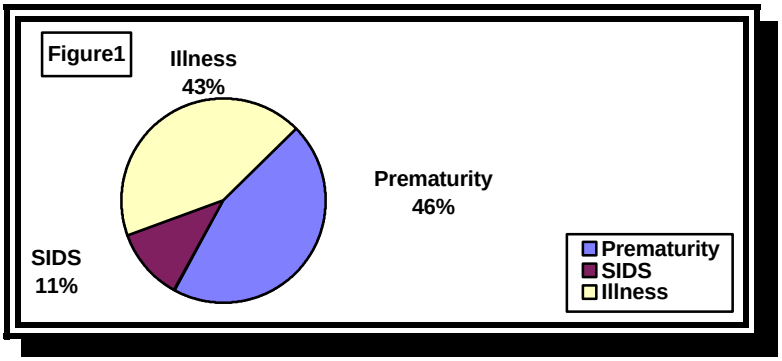
A total of 110 Davidson County children between the ages of birth and 17 years died in Tennessee during the 1997 calendar year. This number does not include data on Davidson County residents who died in other states. The National Association for Public Health Statistics and Information System restricts access to data on out of state deaths to the Tennessee Vital Records staff. The Team completed review of all 110 cases. Findings are evaluated within the sub-categories taken from the death certificate for manner of death. These categories are *natural, accident, suicide, homicide* and *could not be determined.* Following these findings are some overall demographic findings.

Natural was the manner of 79 deaths of children during 1997, representing 72 % of the child deaths.

Natural was the leading manner of death among children in 1997. There were 79 children, 72% of the total cases, whose deaths were attributed to a natural manner. Causes of death listed under the Natural manner include known illness or medical conditions, prematurity, and SIDS. Planning District 14 (Donelson - Hermitage) led the county with 14 deaths, followed by Planning District 5 (East Nashville - Inglewood) and district 12 (Tusculum - Crieve Hall) each with 10 deaths. (See Appendix 6A and 6B.)

Known Illness or medical condition was listed as the cause of death in 43% or 34 of the deaths listed under natural manner. These deaths are from a variety of different medical conditions. Those children who were under one year of age, for whom prematurity was the primary contributing factor, are not counted in this group. They are counted under prematurity. Prematurity makes up the second largest group dying from what is considered a natural manner.

Figure 1: Deaths due to Natural Manner (79 of total cases)



Deaths due to Natural Manner

Prematurity is defined as any child born after 22 weeks of gestation and less than 38 weeks gestation. The neonate period is from birth to 28 days and the postnatal period is from 28 days to 1 year of life. Prematurity is the leading cause of natural deaths contributing to 46% or 36 of the deaths by this manner in 1997. Five of these cases were considered non-viable infants and did not fit into the above definition of prematurity. They were born at 16 weeks, 19 weeks, 20 weeks and two (2) at 21 weeks. They are counted here because they were issued birth certificates as live births and their cause of death was extreme prematurity. The Team has recommended that the State look at another way of counting these non-viable infants.

White males made up the largest group with 14 deaths during the neonate period. All three deaths in the postnatal period were in African Americans.

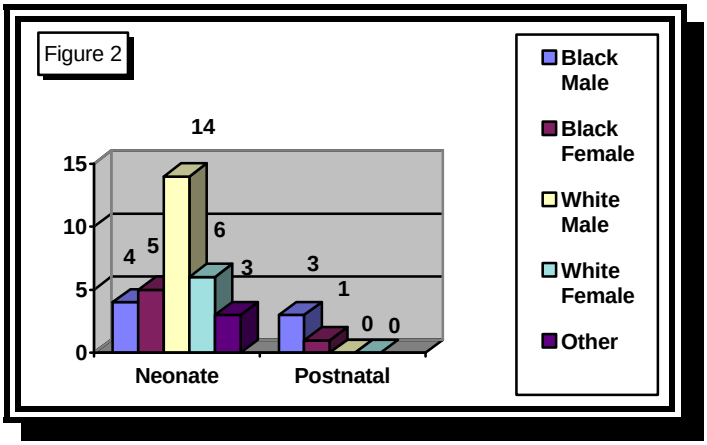
This year 26 (72%) of the 36 premature infants died within the first twenty-four hours of life. Twelve (12) infants died as the result of prematurity (33%) that was complicated by a multiple birth situation.

The team tried to look at the effects of drug use on premature delivery but found that information on the birth certificate about drug use was self reported and not reported by the physician who signed the birth certificate. Without access to the mother's obstetrical record we were unable to determine if she had a history of drug use during any part of her pregnancy.

Illustrative Vignette: Twins were born to a 24 year old married women. She entered prenatal care in the third month and had 11 visits to the doctor prior to entering early labor. The twins were born at 26 weeks. One twin weighed 15 ounces; the other twin weighed 2 pounds 1 ounce. Both died within the first 24 hours. The first from prematurity complicated by congestive heart failure and the second from prematurity. Mother had a prior history of receiving treatment for alcoholism.

Infants who died from causes related to their prematurity were highest in Planning District 14 (Donelson - Hermitage) with 9 deaths. There were two sets of twins who died in this area. The next highest number of deaths due to prematurity was in District 5 (East Nashville - Inglewood) with 7 deaths. There was one set of twins in District 5. (See Appendix 6C and 6D)

Figure 2: AGE, RACE AND SEX BREAKDOWN OF PREMATURITY CASES
(36 cases)



AGE, RACE AND SEX BREAKDOWN OF PREMATURITY CASES

SIDS

The National Institute of Child Health and Human Development (NICHHD) defined SIDS as "The sudden death of an infant under 1 year of age that remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history." SIDS was the diagnosis in 11% or 9 of the deaths. The age of the infants ranged from 1 to 7 months. Six died before they were three months. Only one child was premature. Three mothers reported smoking during pregnancy. Two infants were found face down and three on their back. There was no information on the other cases as to their position when found.

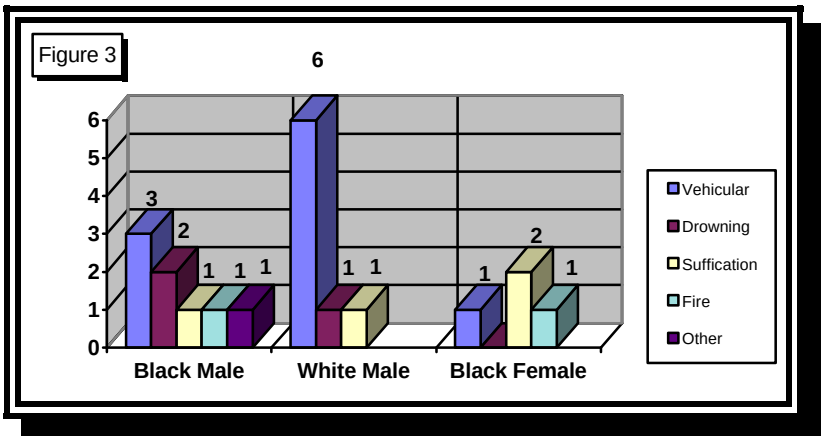
Accident was the manner of 20 deaths of children during 1997, representing 18% of the total deaths.

Accidental deaths was the second leading manner of death of Davidson County children in 1997, accounting for 20 deaths, 18% of the total. This manner includes deaths due to causes such as vehicular accidents, drowning, suffocation and fires. Males made up 80% of the 20 accidental deaths. This number was evenly divided between African American and white males. The remaining 4 accident victims were African American females. African Americans represented a disproportionally high number of accident victims.

Accidental deaths were highest in Planning District 5 (East Nashville - Inglewood) and District 12 (Tusculum - Crieve Hall). Each had three children die as a result of an accident. (See Appendix 6E)

Drowning deaths made up 3 of the accidental deaths, fires contributed to 4 deaths and suffocation to the remaining 4.

Figure 3: Accidental Causes By Race And Gender (20 cases)



Accidental Causes By Race And Gender

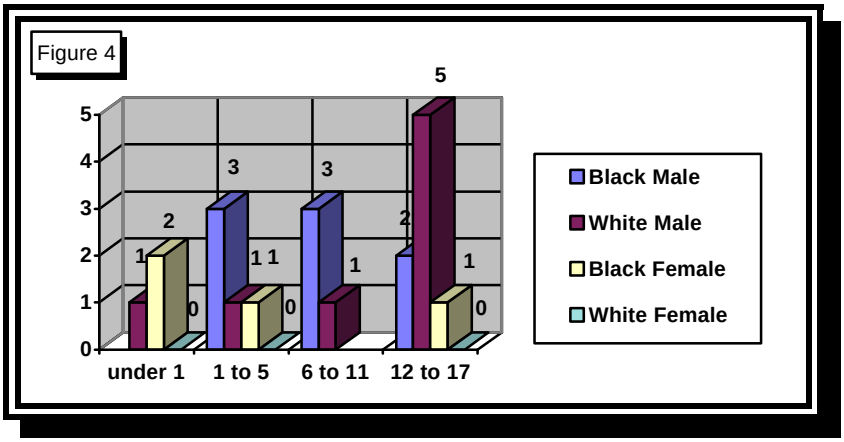
Illustrative vignette: A three year old child was outside playing while his father was working in the yard. The child had taken off his shoes and either fell or jumped into the pool. His father later found him there. Efforts to revive him were unsuccessful.

Incidents of children drowning in home pools have caused the Team continued concern regarding the laws governing one and two family residential swimming pools. The Team again looked into the codes governing pools, which only apply to pools built after 1992. The Metro Health Department has agreed to inspect pools where a child has drowned and make recommendations that will help the homeowner to take safety precautions to prevent drownings. The Health Department will also run a public service announcement on pool safety measures each spring. Health Department Staff will work with Codes inspectors to implement the providing of information on pool safety measures related to young children. It is recommended that this information be provided to homeowners at the time of the initial inspection.

Vehicular accident was the largest cause of accidental deaths - accounting for 10 victims (50%). Males comprised 90% of the vehicular accidents. Two thirds of the males were white and one third African American. The remaining victim was an African American female. Two were pedestrians; one was hit by a car and the other a train. One victim was on a bicycle and collided with a moving vehicle. Of those in automobiles, two were driving and five were passengers. Of the 7 victims in automobiles, 6 had seatbelts present but were not using them. In the seventh case it was not known if seatbelts were present or used.

Illustrative Vignette: Three teens were out driving at a high rate of speed. The driver lost control and the car crashed. No one in the car was wearing a seat belt. A 17-year-old girl and her older sibling were killed and the driver seriously injured. Alcohol may have precipitated the wreck. The 17-year-old had an elevated blood alcohol level. The driver's blood level was unknown at the time the case was reviewed. There are pending charges against him if he survives his injuries.

Figure 4: Accidental Deaths by Race and Age (20 cases)



Accidental Deaths by Race and Age

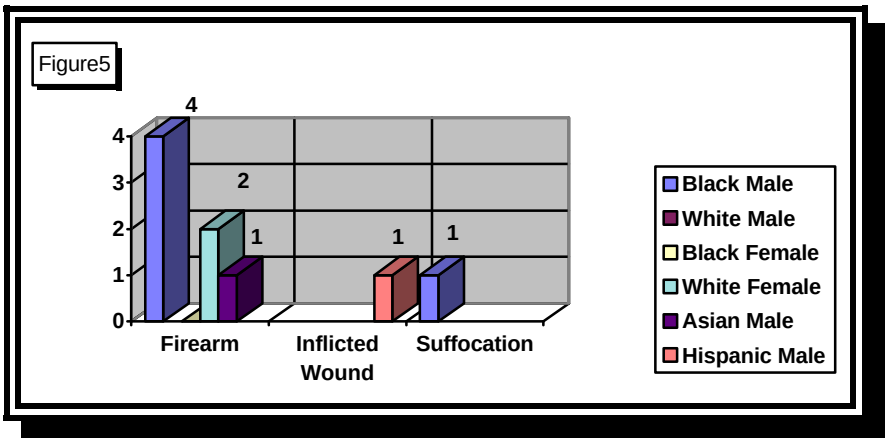
Homicide was the manner of 9 deaths of children during 1997, representing 8% of the total deaths.

Homicide this year made up the third leading manner of death in children. This group included the following causes; firearms, inflicted injury and strangulation. Firearms continue to contribute to the largest group of homicide cases. In 1997 there were 9 deaths (8%) due to homicide. Firearms were involved in 77% (7) of the homicide deaths. Planning District 5 (East Nashville - Inglewood) and District 14 (Donelson - Hermitage) each had 2 children to die as a result of a homicide. (see Appendix 6F)

African American males make up 55% (5) of the homicide victims and three-fourths (4) of the firearm cases. Males make up 71% (5) of the cases involving firearms.

All the firearm deaths this year were the result of homicides. In each case an unrelated person shot the victim. In three of the cases the victim's involvement in criminal activity contributed to his death. Two of these deaths involved drug related activities. There was one case that was identified as gang related.

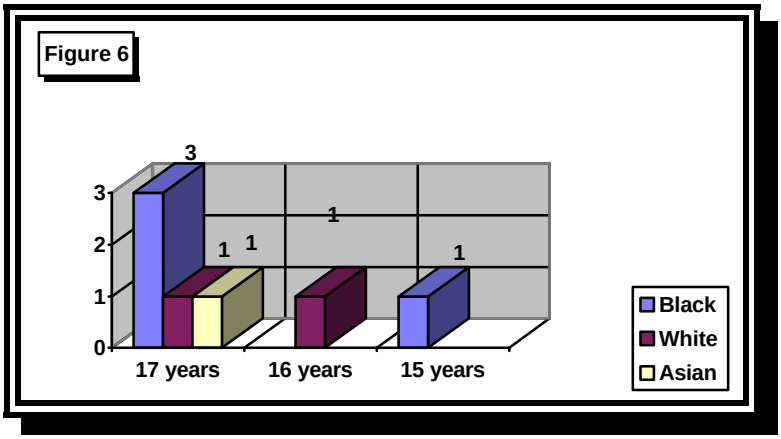
Figure 5: Homicide Causes By Race And Gender (9 cases)



Homicide Causes By Race And Gender

Illustrative Vignette: A 16-year-old girl was working at a fast food restaurant when she and her co-workers were killed in a robbery attempt. Less than a month later a 17-year-old was killed in another fast food restaurant robbery. One of the victims of this robbery survived and an arrest has been made. The man accused of the murders is awaiting trial. The death of these two girls caused the community, and parents in particular to look at the safety of teenagers working late hours in places like fast food restaurants.

Figure 6: Firearm Deaths by Race and Age (7 cases)



Firearm Deaths by Race and Age

Suicide was the manner of 1 death during 1997; this represented 1% of the total

Teen suicides decreased in 1997. There was only one death - a white 13 year old male who strangled himself.

In one case the actual manner of death could not be

deaths.

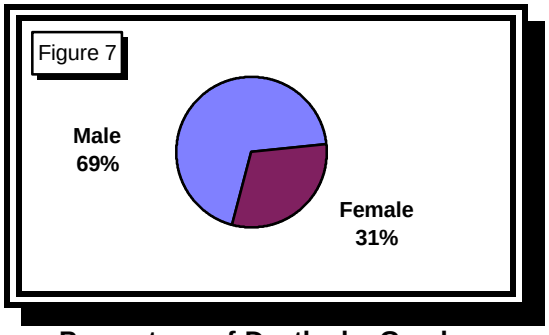
determined even after autopsy and investigation.

Demographic Information

Planning District 14, Donelson – Hermitage had the highest number of child deaths (18 cases). District 9, Downtown area had no child deaths, followed by District 1, Joelton, with 1 death. (See Appendix 6G and 6H) East Nashville Inglewood, District 5, had the second highest number of child deaths during 1997.

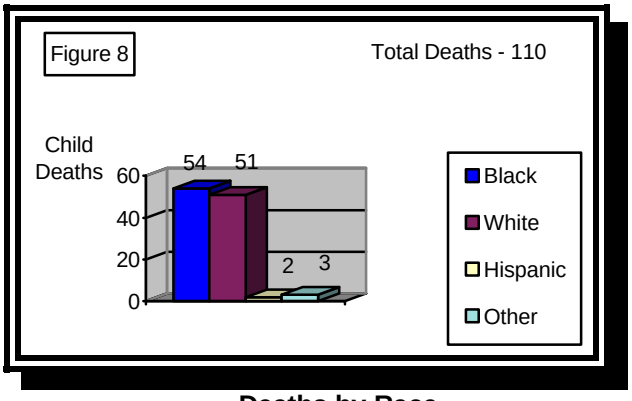
Males made up 69% or 76 of the deaths as compared to 31% or 34 females. When looked at by race, 51 (46%) of the children were white, 54 (49%) African American, 2 Hispanic and 3 of other races. There continues to be a disproportional high number of deaths among African American children. African American children make up 49% of the deaths in the county but only 28.6% of the under age 18 population in the 1990 census. Deaths among African American males are higher than other groups in preventable deaths such as accidents and homicides. The only children who died during the postnatal period where prematurity was the main contributing factor were also African American.

Figure 7: Percentage of Deaths by Gender (110 cases)



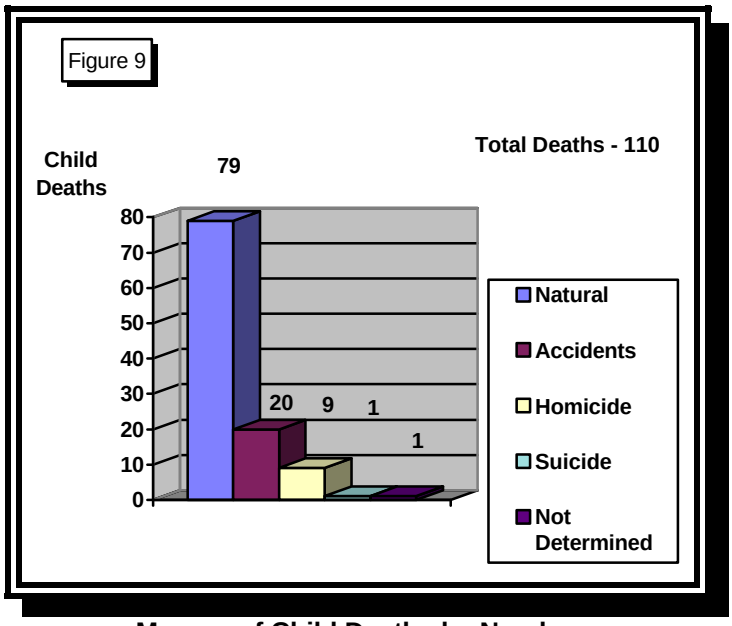
Percentage of Deaths by Gender

Figure 8: Deaths by Race (110 cases)



Deaths by Race

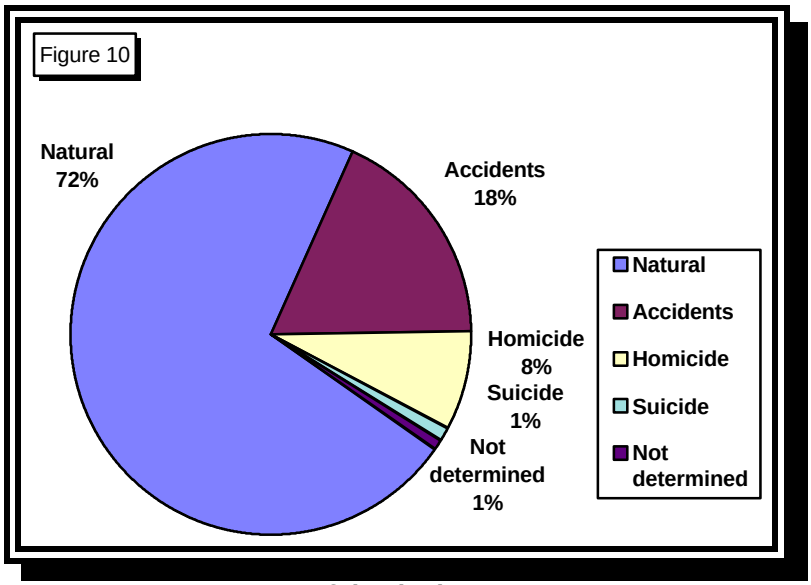
Figure 9: Manner of Child Deaths by number (110 cases)



Manner of Child Deaths by Number

Over 72% or 79 deaths were attributed to natural causes. Natural causes is followed by accidents (18%), homicide (8%) and suicide (1%). The manner of death could not be determined in 1% of the cases.

Figure 10: Manner of child deaths in percents (110 cases)



Manner of deaths by percents

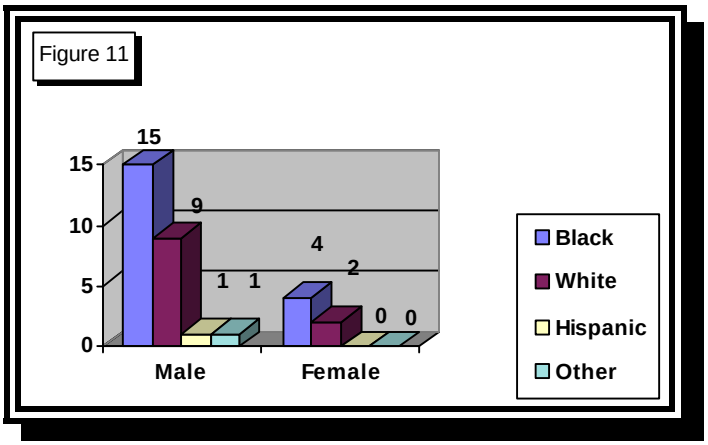
Preventable Deaths

One question the Team considers is whether the death could have been prevented. As a result of this study it was determined that 32 (29%) of the deaths were within the capability of the child or his parents to prevent. Most of these

cases were deaths due to accidents, homicides and suicides. There were, however, some where more timely and prudent use of medical care by the family would have prevented the death. Males made up 26 (81%) of the preventable deaths. African American males led with 15 cases, followed by white males with 9.

The Team also determined that another 15 (14%) may have been preventable. These cases either did not have enough information on which to make a formal decision or depended on changes in behavior of a third party.

Figure 11: Preventable deaths by race and sex (32 cases)



Preventable deaths by race and sex

Table 1: Summary of Findings

Child Deaths	110		Total for 1997
Manner of Death			
	30		**Injury related death**
		10	Accident - Traffic
		10	Accident - Non-traffic
		9	Homicide
		1	Suicide
	79		**Non-Injury deaths**
		79	Natural
	1		Could not determine
Cause of Death			
	9		SIDS
	70		Natural Cause
	7		Firearm
	10		Vehicular
	6		Suffocation
	1		Inflicted injury
	3		Drowning
	2		Fire
	1		Complications of drug levels
	1		Not determined
Age			
	69		Total Infants (birth to 12 months)
		38	Neonate (1-28 days)
		31	Postnatal (29 days to 1 year)
	8		1-4 years (pre-school)
	8		5-11 years (school age)
	25		12-17 years (adolescents)

Race by Gender

	African American	White	Hispanic	Other	Total
Female	18	15	0	1	34
Male	36	36	2	2	76
Total	54	51	2	3	110

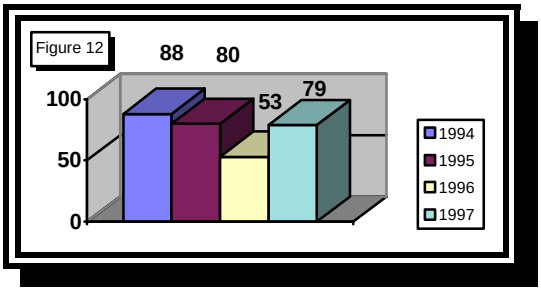
Four Year Data Summary

At this writing, the Child Death Review Team has data for 1994, 1995, 1996 and 1997. 1996 figures were adjusted from the last report to reflect the receipt of several late death certificates. After two years of decreasing numbers of child deaths the figures for 1997 show an upward movement.

Natural as Manner of Death

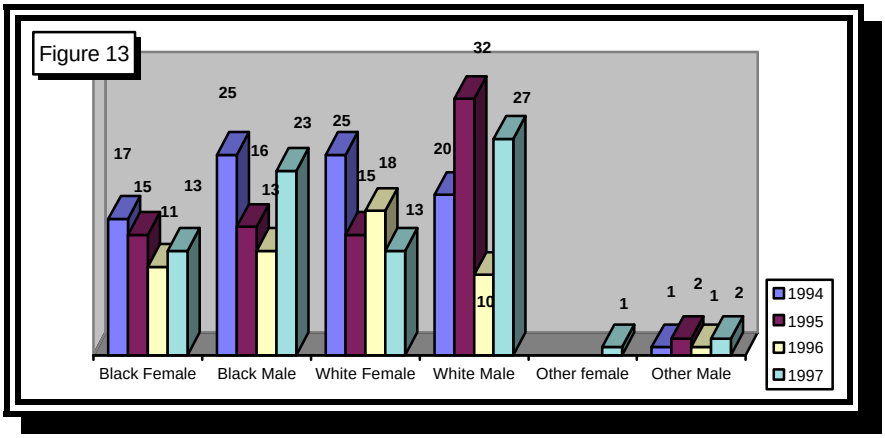
Natural manner continues to be the leading manner of death of Davidson County children. Until 1997 there appeared to be a continued decrease in the number of deaths in both African American males and females. In 1997 the number of deaths in African Americans rose but the overall percentage was 45% in 1996 and 1997. Natural deaths comprise 66% of all child deaths between 1994 and 1997.

Figure 12: Natural deaths by year



Natural deaths by year

Figure 13: Natural Manner of death by year, race and gender (300 cases)

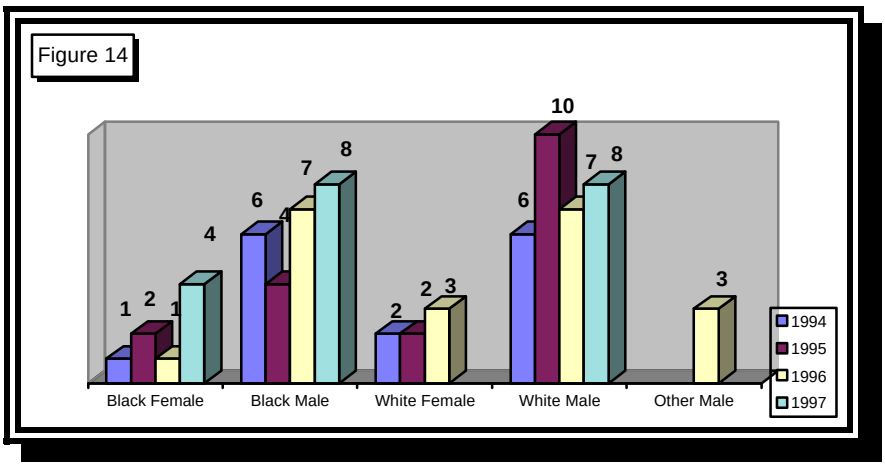


Natural Manner of death by year, race and gender

Accidental as Manner of Death

Accidental deaths showed a slight increase from 1994 to 1995 then showed a 20% increase from 1995 to 1996. This last year there was a slight decrease. Males were involved with the largest percentage of accidental deaths, 84% of the total. White males had the largest number over the four year span (42%) with African American males following closely with 34% of the total.

Figure 14: Accidental Manner by year, race and gender (74 cases)

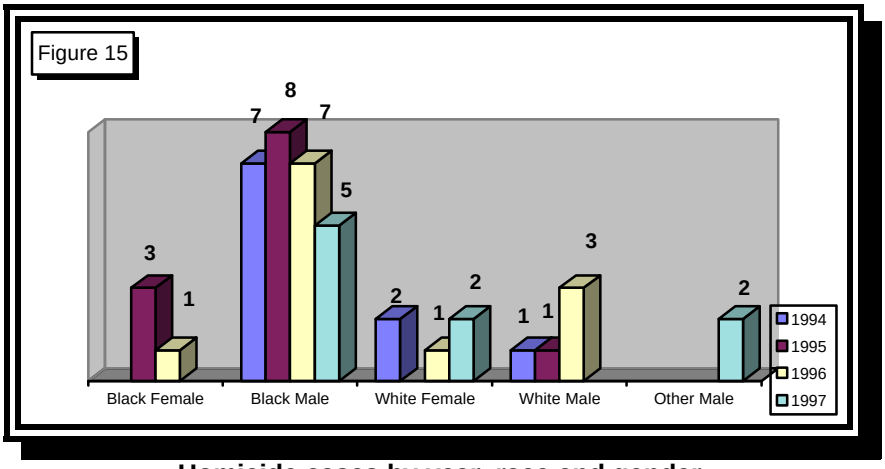


Accidental Manner by year, race and gender

Homicide as Manner of Death

Homicides increased 17% from 1994 to 1995 and remained unchanged in 1996. In the last year homicides showed a 25% decrease, down from 12 to 9. The continued disturbing factor is that 72% of the homicide victims over the last four years were African American. African American males accounted for 62% of the deaths or 27 of the 43 cases between 1994 and 1997.

Figure15: Homicide cases by year, race and gender (43 cases)

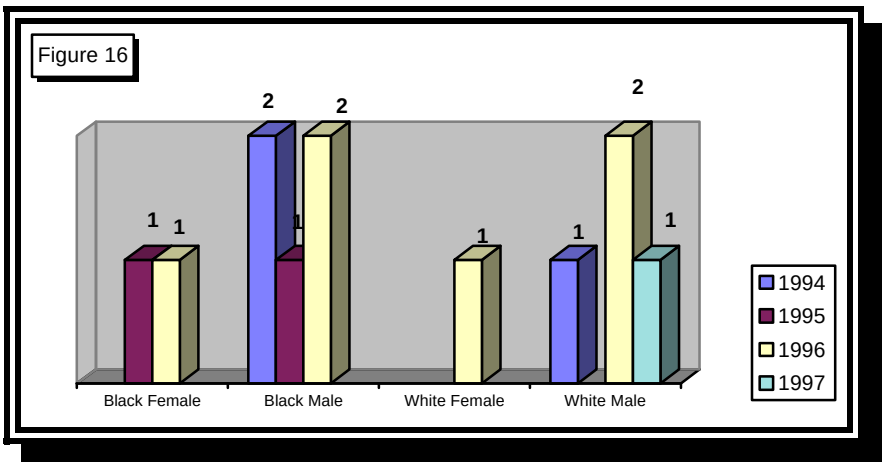


Homicide cases by year, race and gender

Suicide as manner of death

Suicide cases doubled in 1996 to six cases but have sharply dropped to one case in 1997. Males continue to make up the largest group. African American males lead with five suicides since 1994 followed by white males with four cases. The Team's Subcommittee on Teen Suicides is closely monitoring these trends. In 1997, the Team sponsored a Teleconference entitled *Preventing Adolescent Suicide* as part of its continued effort on this topic.

Figure 16: Suicide cases by year and race and gender (12 cases)

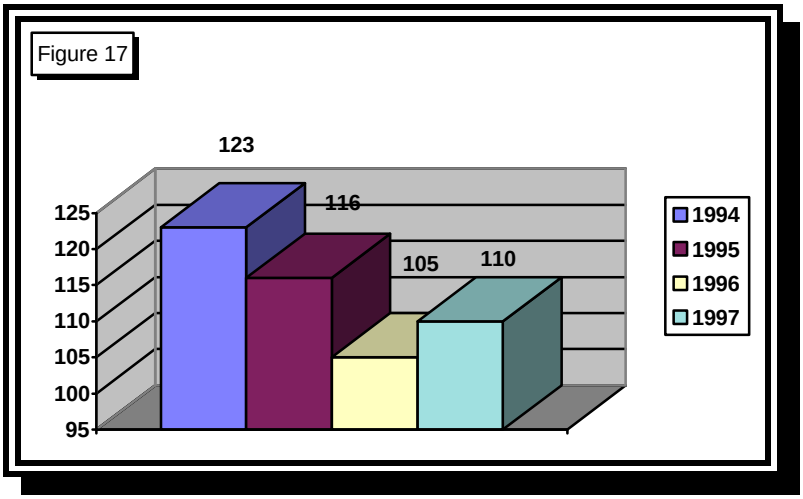


Suicide cases by year and race and gender

Demographic Data

From 1994 to 1996 Davidson County had shown a downward trend in child deaths. In 1997, child deaths increased to 110 from 105 in 1996. A total of 454 children under 18 died in Davidson County in the four years between January 1, 1994 and December 31, 1997.

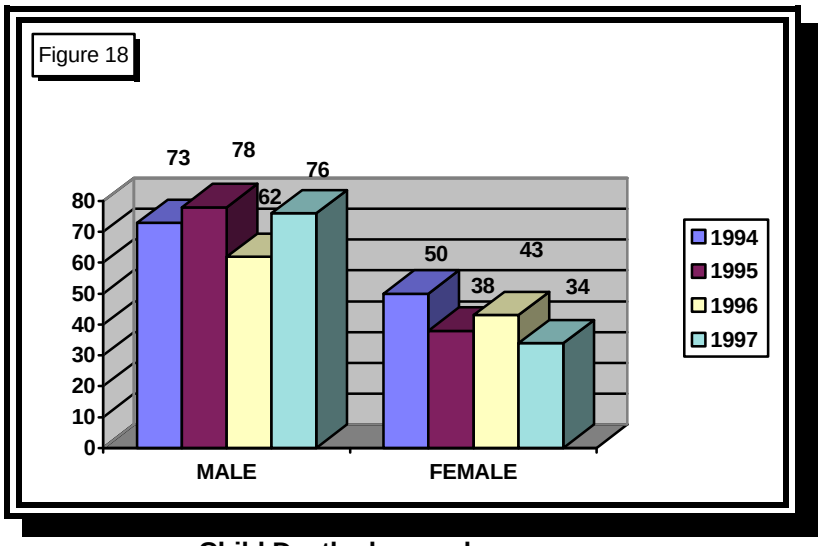
Figure 17: Number of deaths by year



Number of deaths by year

When looking at total deaths by gender over the four year period, males have outnumbered females by 64% to 36%. The percentage of male deaths ranged from 59% to 69%.

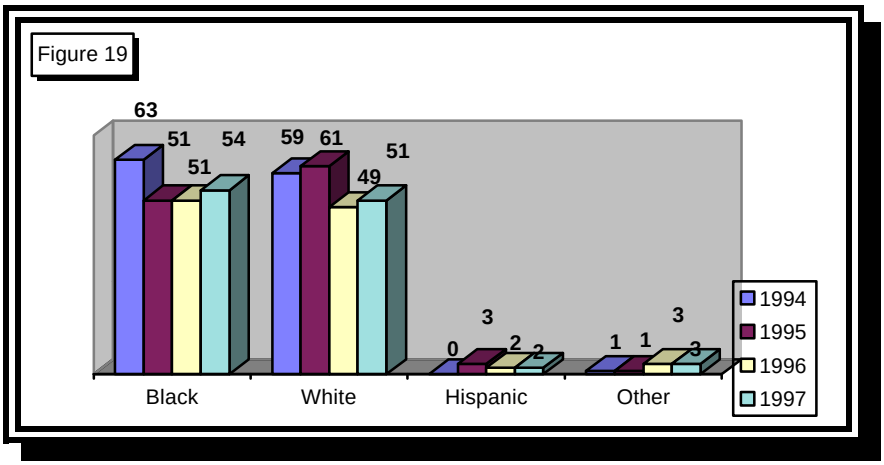
Figure 18: Child Deaths by gender per year



Child Deaths by gender per year

When looked at by race, the number of deaths among African Americans remains high in relation to the percentage of the population. Although only 28.6% of the population under 18 are African Americans, African Americans made up nearly half (48%) of the deaths over the last four years. In three of the last four years the number of deaths among African Americans has exceeded that of white Americans.

Figure 19: Child deaths by race and year



Child deaths by race and year

As children grow older, the causes of death change from known illnesses to causes that are preventable or potentially preventable in nature. Over the past four years, most infant deaths were caused by known illnesses (200) and SIDS (39). Illness was the leading cause of death in children between the ages of 1-4 and 5-11. However, firearms were the leading

cause of death for children between the ages of 12-17. Forty-three children in this age group died as a result of firearms between 1994 and 1997.

Table 2: Leading Causes of death ranked by age group

Leading Causes of Death In Davidson County
Four year totals 1994-1997

Rank	Under 1 year	1-4	5-11	12-17
1	Illness (200)	Illness (21)	Illness (22)	Firearm (43)
2	SIDS (39)	Fire/Burns (6)	Vehicular (7)	Illness (32)
3	Suffocation (8)	Drowning (6)	Drowning (3)	Vehicular (31)
4	Lack of adequate care (2)	Inflicted Injury (5)	Fire Arm (1)	Suffocation (3)
5	Fire/burns (2)	Vehicular (3)	Suffocation (1)	Poison/drug overdose (2)
6	Inflicted Injury (2)	SIDS (1)	Fire/Burns (1)	Lack of adequate care (2)
7	Vehicular (1)	Firearm (1)	Lack of Adequate care (1)	Fire/burn (1)
8		Lack of adequate care (1)	Inflicted injury (1)	Inflicted injury (1)
9			Other (1)	Other (1)

Causes of death are ranked within each age group. Highlighted causes are those that are considered preventable or potentially preventable.

1997 Nashville Child Death Review Team recommenda -tions

Team recommendations are listed below:

1. Team members agreed to convene a meeting, including but not limited to the OB/GYN Society, Tennessee Perinatal Association, March of Dimes, Metro Police Department, and the District Attorney's office to discuss the topic of prenatal child abuse. The goal of the meeting is to determine possible interventions (and/or solutions) for dealing with substance abuse during pregnancy.

2. The wording regarding risk factors on birth certificates should be clearer.

3. Nashville's Child Death Review Team would like to see a meeting between the Medical Examiner's office and the Nashville Fire Department Medical Director's office, to discuss whether paramedics may not begin or discontinue resuscitation on children who are obviously dead. Dr. Levy's office would like to have an investigator at the scene before a deceased child is removed.

4. The State Child Death Review Team should recommend a change in the way infant child death statistics are counted. Non-viable infant deaths should be captured in another category or excluded from infant deaths in order to demonstrate a clearer picture of infant mortality. To date the Team has reviewed several deaths that fall into the non-viable category.

5. The Metro Health Department should do a pool safety campaign annually. Channel 8 has a commercial showing a child drowning that should be aired on other channels.

6. The quality assurance process at the Department of Children's Services (DCS) should include a documented review of all DCS child death cases.

1997 Nashville Child Death Review Team Accomplish-ments

1. One hundred and ten child deaths were reviewed during 1997.

2. The Team sent letters to hospital administrators and medical records directors asking them to ensure that information on birth and death certificates is the same as information in the medical records.

3. Team members reviewed the reimbursement policy for SIDS autopsies in Tennessee.

4. Team members reviewed the law governing pool safety at private residences, apartments, and condominiums. A letter was sent to the State Child Death Review Team recommending self-closing self-latching gates on all pools.

5. On October 28, 1997, the Team invited all interested professionals from middle and high schools to a teleconference entitled *Preventing Adolescent Suicide.* The teleconference was held at the Metro Health Department.

6. All Metro Council-members were invited to a Team meeting; listed below are the eight (8) members who attended:

   Melvin Black, District 2
   Willis McAllister, District 21
   Regina Patton, District 1
   Vic Varallo, Council-at-large
   Howard Earl Campbell, Sr., District 7
   Phil Ponder, District 12
   Michelle Arriola, District 26
   Vic Lineweaver, District 35

7. Doctors Stephanie Bailey and Suzanne Starling met with Davidson County Judges to distribute and summarize the findings in the 1996 Annual CDRT Report.

EXECUTIVE ORDER NO. 94-01

APPENDIX 1

Subject: **Establishment of Child Death Review Team of the Metropolitan Government**

I, Philip Bredesen, Mayor of The Metropolitan Government of Nashville and Davidson County, by virtue of the power and authority vested in me, do hereby direct and order that:

1. A Child Death Review Team is hereby established for The Metropolitan Government of Nashville and Davidson County.

2. The Team shall have 10 members, consisting of the following:

   Director of the Metropolitan Department of Health
   Director of the Metropolitan Department of Social Services
   Chief of the Department of Metropolitan Police
   County Medical Examiner of Davidson County
   Medical Director of "Our Kids, Inc."

   The following elected officials are requested to serve as members of the Team or to designate representatives from their offices to do so:

   District Attorney General of the 20th Judicial District of Tennessee
   Judge of the Juvenile Court for Davidson County

   In addition, the Commissioner of the Tennessee Department of Human Services is requested to designate a representative to serve on the team.

   In addition to the foregoing, there shall be two other members, at least one of whom shall be a board certified pediatrician or a board certified child psychiatrist.

3. The purpose of the Team is to review the death of any child below 18 years of age legally residing in Davidson County at the time of death, irrespective of the location where the death occurred. In connection with its investigation, the Team shall assist in identifying information which could be pertinent in determining the manner of death in any unexpected child fatalities; identify preventable deaths and strategies for the prevention of future childhood fatalities, including any which might be related to limited access to health care; and collect statistical and other data and report annually to the Mayor relating how children are dying in Nashville and recommending appropriate strategies for prevention.

4. The Director of the Metropolitan Department of Health shall serve as the Chair of the Team.

5. The Team shall meet monthly. Special meetings may be called at the discretion of the Chair; the District Attorney; or the Medical Examiner.

6. Members of the Team shall serve without compensation; however, travel and related expenses may be reimbursed pursuant to the Metropolitan Government's travel regulations, with the approval of the Director of Finance.

7. The Team shall observe confidentiality to the maximum extent permitted by law.

8. The Director of Law or a designee from the Department of Law shall serve as legal advisor to the Team.

9. Subject to the approval of the appropriate department head, the Team may utilize the services of any staff or resources of the Metropolitan Government. The Chair may include non-voting advisory members on an ad hoc basis to assist with specific cases or issues under review.

This order shall become effective on January 1, 1994.

ORDERED THIS 7th DAY OF MARCH, 1994.

Philip Bredesen
Mayor

CHILD FATALITY REVIEW AND PREVENTION ACT OF 1995

CHAPTER 142
CHILD FATALITY REVIEW AND PREVENTION

Section

68-142-101. Short title.

The chapter shall be known as and may be cited as the “Child Fatality Review and Prevention Act of 1995.”

[Acts 1995. Ch. 511. § 1.]

68-142-102. Child fatality prevention team.

There is hereby created the Tennessee child fatality prevention team, otherwise known as the state team. For administrative purposes only, the state team shall be attached to the department of health.

68-142-103. Composition

The state team shall be composed as provided herein. Any ex officio member, other than the commissioner of health, may designate an agency representative to serve in such person's place. Members of the state team shall be as follows:

(1) The commissioner of health, who shall chair the state team;

(2) The attorney general and reporter;

(3) The commissioner of children's services;

(4) The director of the Tennessee bureau of investigation;

(5) A physician nominated by the state chapter of the American Medical Association;

(6) A physician to be appointed by the commissioner of health who is credentialed in forensic pathology, preferably with experience in pediatric forensic pathology;

(7) The commissioner of mental health and mental retardation;

(8) A member of the judiciary selected from a list submitted by the chief justice of the Tennessee supreme court;

(9) The executive director of the commission on children and youth;

(10) The president of the state professional society on the abuse of children;

(11) A team coordinator, to be appointed by the commissioner of health;

(12) The chair of the select committee on children and youth;

(13) Two (2) members of the house of representatives to be appointed by the speaker of the house, at least one (1) of whom shall be a member of the house health and human resources committee; and

(14) Two (2) senators to be appointed by the speaker of the senate, at least one (1) of whom shall be a member of the senate general welfare, health and human resources committee.

[Acts 1995, Ch. 511, § 1; 1996, ch. 1079, § 152.]

68-142-104. Voting members – Vacancies.

All members of the state team shall be voting members. All vacancies shall be filled by the appointing or designating authority in accordance with the requirements of § 68-142-103.

[Acts 1995, ch. 511, § 1.]

68-142-105. Duties of state team.

The state team shall:

(1) Review reports from the local child fatality review teams;

(2) Report to the governor and the general assembly concerning the state team's activities and its recommendations for changes to any law, rule, and policy that would promote the safety and well-being of children;

(3) Undertake annual statistical studies of the incidence and causes of child fatalities in this state. The studies shall include an analysis of community and public and private agency involvement with the decedents and their families prior to and subsequent to the deaths;

(4) Provide training and written materials to the local teams established by this chapter to assist them in carrying out their duties. Such written materials may include model protocols for the operation of local teams;

(5) Develop a protocol for the collection of data regarding child deaths;

(6) Upon request of a local team, provide technical assistance to such team, including the authorization of another medical or legal opinion on a particular death; and

(7) Periodically assess the operations of child fatality prevention efforts and make recommendations for changes as needed.

[Acts 1995, ch. 511, § 2.]

68-142-106. Local teams – Composition – Vacancy – Chair – Meetings.

(a) There shall be a minimum of one (1) local team in each judicial district;

(b) Each local team shall include the following statutory members or their designees;

(1) A supervisor of social services in the department of children's services within the area served by the team;

(2) The regional health officer in the department of health in the area served by the team or such officer's designee, who shall serve as interim chair pending the election by the local team;

(3) A medical examiner who provides services in the area served by the team;

(4) A prosecuting attorney appointed by the district attorney general;

(5) The interim chair of the local team shall appoint the following members to the local team;

(A) A local law enforcement officer;

(B) A mental health professional;

(C) A pediatrician or family practice physician;

(D) An emergency medical service provider or firefighter; and

(E) A representative from a juvenile court.

(c) Each local child fatality team may include representatives of public and nonpublic agencies in the community that provide services to children and their families;

(d) The local team may include non-statutory members to assist them in carrying out their duties. Vacancies on a local team shall be filled by the original appointing authority;

(e) A local team shall elect a member to serve as chair;

(f) The chair of each local team shall schedule the time and place of the first meeting, and shall prepare the agenda. Thereafter, the team shall meet no less often than once per quarter and often enough to allow adequate review of the cases meeting the criteria for review.

[Acts 1995, ch. 511, § 3; 1996, ch. 1079, § 152.]

68-142-107. Duties of local teams.

(a) The local child fatality review teams shall:

(1) Be established to cover each judicial district in the state;

(2) Review, in accordance with the procedures established by the state team, all deaths of children seventeen (17) years of age or younger.

(3) Collect data according to the protocol developed by the state team;

(4) Submit data on child deaths quarterly to the state team;

(5) Submit annually to the state team recommendations, if any, and advocate for system improvements and resources where gaps and deficiencies may exist; and

(6) Participate in training provided by the state team.

(b) Nothing in this chapter shall preclude a local team from providing consultation to any team member conducting an investigation.

(c) Local child fatality review teams may request a second medical or legal opinion to be authorized by the state team in the event that a majority of the local team's statutory membership is in agreement that a second opinion is needed.

[Acts 1995, ch. 511, § 4.]

68-142-108. Powers of local team – Limitations – Confidentiality of state and local team records.

(a) The local team shall have access to and subpoena power to obtain all medical records and records maintained by any state, county or local agency, including, but not limited to, police investigations data, medical examiner investigative data and social services records, as necessary to complete the review of a specific fatality.

(b) The local team shall not, as part of the review authorized under this chapter, contact, question or interview the parent of the deceased child or any other family member of the child whose death is being reviewed.

(c) The local team may request that persons with direct knowledge of circumstances surrounding a particular fatality provide the local team with information necessary to complete the review of the particular fatality; such persons may include the person or persons who first responded to a report concerning the child.

(d) Meeting of the state team and each local team shall not be subject to the provisions of title 8, chapter 44, part 1. Any minutes or other information generated during official meetings of state or local teams shall be sealed from public inspection. However, the state and local teams may periodically make available, in a general manner not revealing confidential information about children and families, the aggregate findings of their reviews and their recommendations for preventive actions.

(e) (1) All otherwise confidential information and records acquired by the state team or any local child fatality review team in the exercise of the duties are confidential, are not subject to discovery or introduction into evidence in any proceedings, and may only be disclosed as necessary to carry out the purposes of the state team or local teams.

(2) In addition, all otherwise confidential information and records created by a local team in the exercise of its duties are confidential, are not subject to discovery or introduction into evidence in any proceedings, and may only be disclosed as necessary to carry out the purposes of the state or local teams. Release to the public or the news media of information discussed at official meetings is strictly prohibited. No member of the state team, a local team nor any person who attends an official meeting of the state team or a local team, may testify in any proceeding about what transpired at the meeting, about information presented at the meeting, or about opinions formed by the person as result of the meeting.

(3) This subsection shall not, however, prohibit a person from testifying in a civil or criminal action about matters within that person's independent knowledge.

(f) Each statutory member of a local child fatality review team and each non-Statutory member of a local team and each person otherwise attending a meeting of a local child fatality review team shall sign a statement indicating an understanding of and adherence to confidentiality requirements, including the possible civil or criminal consequences of any breach of confidentiality.

[Acts 1995, ch. 511, § 5.}

68-142-109. Staff and consultants.

To the extent of funds available, the state team may hire staff or consultants to assist the state team and local teams in completing their duties.

{Acts 1995, ch. 511, § 6.]

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Appendix 4

TENNESSEE DEPARTMENT OF HEALTH
CHILD FATALITY REVIEW TEAM
1997 REVIEW/DATA COLLECTION FORM

MCH/7/97

The information on this form was entered into the data system on _____ by _____

This form is confidential

Judicial District No.: _____ Child Death Year/No.: ___/___/___/___/___/___

Child's Name: _____ (Last / First / Middle)

Date of Death: ___/___/___ Date of Birth: ___/___/___ Sex: ☐ Male ☐ Female

Address: _____ (Street / City) Zip Code: _____

Race: ☐ White ☐ African American ☐ Hispanic ☐ Asian Other: _____

Mother's Name: _____ (Last / Maiden / First / Middle)

Mother's Social Security Number: ___-___-___ Date of Birth: ___/___/___ (Month / Day / Year)

Census Tract: _____ County of Residence _____

Birth Weight: ___/___ (kg / gm) ___/___ (lb / oz) Clinical Estimate of Gestation (weeks): _____

Abnormal Conditions: _____ Congenital Anomalies: _____

Prenatal Care Questions:
Specify Month Prenatal Care Began _____ ☐ No Prenatal Care ☐ Unknown
Number of Prenatal Visits _____ ☐ No Visits ☐ Unknown

Risk Factors:
Tobacco Use ☐ Yes ☐ No No. of cigarettes per day _____
Alcohol Use ☐ Yes ☐ No No. of drinks per day _____
Chemical Substance Abuse ☐ Yes ☐ No Specify _____

Death Certificate Number _____

Manner of Death on Death Certificate: ☐ Homicide ☐ Suicide ☐ Accidental ☐ Natural ☐ Pending Investigation ☐ Could not be determined ☐ Blank

Place of Death: ☐ Hospital Inpatient ☐ Hospital Emergency Room ☐ Child's Residence ☐ Relative/Friends Home ☐ Institutional Setting ☐ Body of Water ☐ In Transit ☐ Child Care ☐ At Scene of Accident ☐ Other _____

Is the Death Certificate adequate/complete? ☐ Yes ☐ No

Was Autopsy Performed? ☐ Yes ☐ No ☐ Unknown

If Yes, Location: ☐ Medical Examiner _____ ☐ Hospital _____ ☐ Other _____

Review Team Comments/Recommendations: _____

1st Review: ___/___/___ 2nd Review: ___/___/___ 3rd Review: ___/___/___

1. CAUSE AND CIRCUMSTANCES OF DEATH
(Complete on back)

☐ Sudden Infant Death Syndrome ☐ Vehicular
☐ Lack of adequate care ☐ Drowning
☐ Prematurity ☐ Inflicted injury
☐ Illness or other natural cause ☐ Fire/Burn
☐ Poisoning/Overdose ☐ Other cause not listed above
☐ Firearm
☐ Suffocation/Strangulation ☐ Unknown cause

2. Prior Child Protective Services Involvement? ☐ Yes ☐ No

3. Other Public/Private Agency Involvement?
☐ Yes ☐ No ☐ Unknown
Name of Agency:
Health Department:
☐ CSS ☐ WIC ☐ HV Program ☐ Other
DHS: ☐ FF ☐ Food Stamps ☐ Other
☐ Counseling/Mental Health ☐ Police/Sheriff
☐ TennCare ☐ Juvenile
Court
☐ Other _____

4. Was there an apparent delay in seeking medical treatment?
☐ Yes ☐ No ☐ Unknown

5. Suspected Child Abuse/Neglect Fatality
☐ Yes ☐ No ☐ Unknown

6. Overall was the Investigation adequate? ☐ Yes ☐ No
If No, was the problem with:
☐ Autopsy ☐ Police Follow-up
☐ Hospital Review ☐ Death Scene Investigation
☐ Interagency Cooperation ☐ CPS Follow-up
☐ Other _____

7. Based on available information, was this death preventable?
☐ Yes ☐ No ☐ Unknown

8. Manner of death as determined by the CFRT team:
☐ Homicide ☐ Accidental ☐ Natural ☐ Suicide
☐ Could not be determined ☐ Undetermined due to suspicious circumstances

Recommended For Additional Review? ☐ Yes ☐ No

Which Reports/Records are requested for full review?
☐ Law Enforcement ☐ School ☐ DHS ☐ Med Exam Autopsy
☐ Hospital Autopsy ☐ Court ☐ DA Report ☐ Health Dept.
☐ Attending Physician ☐ Other: _____

Date Case Closed by CFRT: ___/___/___

CAUSE AND CIRCUMSTANCES OF THE DEATH*

Complete one of blocks 1-12 as applicable to indicate cause of death.

☐ 1. SUDDEN INFANT DEATH SYNDROME (SIDS)

1. Position of infant on discovery?
   a. ☐ On stomach, face down
   b. ☐ On stomach, face to side e. ☐ Unknown
   c. ☐ On back d. ☐ On side f. ☐ Other

☐ 2. ADEQUATE CARE

1. Apparent lack of supervision? Yes ☐ No ☐
2. Apparent lack of medical care? Yes ☐ No ☐
3. If yes: ☐ a. Malnutrition or dehydration
   ☐ b. Oral water intoxication
   ☐ c. Delayed medical care
   ☐ d. Inadequate medical attention
   ☐ e. Out-of-hospital birth
   ☐ f. Other_____ g. ☐ Unknown

☐ 3. **PREMATURITY (less than 37 weeks gestation)**

☐ 4. **ILLNESS OR OTHER NATURAL CAUSE**

Apparent illness or other condition?
a. ☐ Known condition _____
b. ☐ Unknown

☐ 5. **DROWNING**

1. Place of drowning?
   a. ☐ Creek, river, pond or lake
   b. ☐ Well, cistern, or septic tank
   c. ☐ Bathtub d. ☐ Swimming pool
   e. ☐ Bucket f. ☐ Wading pool
   g. Other:_____ h. ☐ Unknown
2. Location prior to drowning?
   a. ☐ Boat b. ☐ Water edge
   c. ☐ Other:_____ d. ☐ Unknown
3. Wearing floatation device?
   a. ☐ Yes b. ☐ No c. ☐ Unknown
4. Circumstances Unknown

☐ 6. **VEHICULAR**

1. Age of driver_____ ☐ Unknown
2. Position of decedent?
   a. ☐ Driver b. ☐ Pedestrian
   c. ☐ Passenger d. ☐ Back of Truck
   e. ☐ Other:_____ f. ☐ Unknown
3. Type of vehicle?
   a. ☐ Car b. ☐ All-terrain vehicle
   c. ☐ Motorcycle d. ☐ Riding Mower
   e. ☐ Bicycle f. ☐ Farm Tractor
   g. ☐ Other farm vehicle h. ☐ Truck/RV
   u, ☐ Other:_____ j. ☐ Unknown
4. Condition or road?
   a. ☐ Normal b. ☐ Loose Gravel
   c. ☐ Wet d. ☐ Ice or Snow
   e. ☐ Unknown f. ☐ Not applicable
   g. ☐ Other:_____
5. Safety belt or infant seat?
   a. ☐ Present in vehicle, but not used
   b. ☐ None in vehicle c. ☐ Restraint used
   d. ☐ Unknown e. ☐ Not applicable
6. Deceased was wearing helmet?
   a. ☐ Yes b. ☐ No
   c. ☐ Unknown d. ☐ Not applicable
7. Vehicle in which decedent was occupant?
   a. ☐ Operator driving impaired (alcohol/drug)
   b. ☐ Speed/Recklessness indicated:
      (1) Approximate speed: _____ mph
      (2) Speed limit: _____ mph
   c. ☐ Other violation by operator
   d. ☐ Mechanical failure f. ☐ Unknown
   e. ☐ Other:_____ g. ☐ Not applicable
8. Vehicle in which decedent was not occupant?
   a. ☐ Operator driving impaired (alcohol/drug)
   b. ☐ Speed/Recklessness indicated:
      (1) Approximate speed:_____ mph
      (2) Speed limit: _____ mph
   c. ☐ Other violation by operator
   d. ☐ Mechanical failure
   e. ☐ Other:_____ f. ☐ Unknown
   g. ☐ Not applicable
9. ☐ Circumstance unknown

☐ 7. **FIREARM**

1. Person handling the firearm?
   a. ☐ Decedent b. ☐ Other person
   c. ☐ Unknown d. ☐ Not applicable
2. The firearm involved?
   a. ☐ Handgun b. ☐ Rifle
   c. ☐ Shotgun d. ☐ Other: _____
   e. ☐ Unknown f. ☐ Not applicable
3. Age of person handling firearm:
   a. ☐ _____ years b. ☐ Unknown
4. Use of firearm at time of injury?
   a. ☐ Shooting at other person b. ☐ Suicide
   c. ☐ Cleaning d. ☐ Target shooting
   e. ☐ Loading f. ☐ Hunting
   g. ☐ Playing h. ☐ Other: _____
   i. ☐ Unknown j. ☐ Not applicable
5. ☐ Circumstances unknown

☐ 8. **SUFFOCATION/STRANGULATION**

1. Circumstances of the event?
   a. ☐ Other person overlying or rolling over decedent?
   b. ☐ Caused by other person, not overlying or rolling over
   c. ☐ Self-inflicted by decedent
   d. ☐ Not inflicted by any person
   e. ☐ Other:_____ f. ☐ Unknown
2. Object impeding breath?
   a. ☐ Food
   b. ☐ Small object or toy in mouth
   c. ☐ Other person's hand(s)
   d. ☐ Object (e.g., plastic bag) covering victim's mouth/nose
   e. ☐ Object (e.g., rope) exerting pressure on victim's neck
   f. ☐ Other: _____ g. ☐ Unknown
3. Injury occurred in bed, crib, or other sleeping arrangement?
   a. ☐ Yes b. ☐ No c. ☐ Unknown
4. If in bed/crib, due to?
   a. ☐ Hazardous design of crib/bed
   b. ☐ Malfunction/improper use of crib/bed
   c. ☐ Placement on soft sleeping surface (e.g. waterbed)
   d. ☐ Other: _____
   e. ☐ Unknown f. ☐ Not applicable
5. Due to carbon monoxide inhalation?
   a. ☐ Yes b. ☐ No c. ☐ Unknown
6. ☐ Circumstances unknown

☐ 9. **POISONING/OVERDOSE**

1. Name of drug or chemical?
   a. ☐ Name _____
   b. ☐ Unknown c. ☐ Not applicable
2. ☐ Circumstance unknown

☐ 10. **INFLICTED INJURY**

1. Who inflicted the injury?
   a. ☐ Self-inflicted b. ☐ Parent
   c. ☐ Relative: d. ☐ Other _____
2. Person inflicting injury
   a. Age _____ ☐ Unknown
   b. Sex ☐ Male ☐ Female
   c. Race ☐ White ☐ African American
   ☐ Unknown ☐ Other _____
3. Manner in which injury was inflicted?
   a. ☐ Shaken b. ☐ Struck
   c. ☐ Cut/Stabbed d. ☐ Thrown
   e. ☐ Sexual Assault f. ☐ Unknown
   f. ☐ Other: _____
4. Injury inflicted with?
   a. ☐ Sharp object (e.g., knife, scissors)
   b. ☐ Blunt object (e.g., hammer, bat)
   c. ☐ Hot liquid or other substance
   d. ☐ Hands/Feet e. ☐ Fire
   f. ☐ Other: _____ g. ☐ Unknown
5. ☐ Circumstances unknown

☐ 11. **FIRE/BURN** ***(Non-Arson)***

1. If not-fire burn, its source?
   a. ☐ Hot water, etc. b. ☐ Appliance
   c. ☐ Other: d. ☐ Unknown
   e. ☐ Not applicable
2. If ignition/fire its source?
   a. ☐ Oven/stove explosion
   b. ☐ Cooking appliance used as heat source
   c. ☐ Matches d. ☐ Lit cigarette
   e. ☐ Lighter f. ☐ Space heater
   g. ☐ Furnace h. ☐ Explosives
   i. ☐ Fireworks j. ☐ Electrical wire
   k. ☐ Other: _____ l. ☐ Unknown
   m. ☐ Not applicable
3. Smoke alarm present at fire scene?
   a. ☐ Yes b. ☐ No c. ☐ Unknown
4. If alarm present, did it sound?
   a. ☐ Yes b. ☐ No
   c. ☐ Unknown d. ☐ Not applicable
5. Was the fire started by a person?
   a. ☐ Yes b. ☐ No c. ☐ Unknown
6. If started by a person, his/her age?
   a. Age _____ years
   b. ☐ Unknown c. ☐ Not applicable
7. If started by person, his/her activity
   a. ☐ Playing b. ☐ Smoking
   c. ☐ Cooking d. ☐ Other: _____
   e. ☐ Unknown f. ☐ Not applicable
   g. ☐ Suspected arson
8. Type of construction of building burned:
   a. ☐ Wood frame b. ☐ Brick/Stone
   c. ☐ Trailer d. ☐ Other
   e. ☐ Unknown f. ☐ Not applicable
9. ☐ Circumstances unknown

☐ 12. **OTHER CAUSE NOT LISTED ABOVE:**

_____

_____

_____

_____

Form 3308 *Source: B. Ewigman, Missouri, Death Review Team Reporting Form, 1995.

THE CHILD FATALITY REVIEW PROCESS

When a child dies:

- The death certificate is sent from Metropolitan Health Department (MHD) Vital Statistics staff to the (MHD) Child Fatality Review Team staff.

- Birth and death records are sent to Team members. Available records are requested from programs within MHD (HUG, Healthy Start, WIC, etc).

- All Team members search their agency/hospital files, and bring either records or case summaries to Team meetings.

- The Team meets; each case is reviewed; the paperwork is completed.

- MHD Child Fatality Review staff enter the data into a database. Completed data forms are then forwarded to the State Fatality Review Program.

- The Team produces an annual report to assist in the development of data-driven recommendations for prevention of child fatalities.